

**UNITED STATES DISTRICT COURT
DISTRICT OF NEVADA**

CHRISTINE JOHNSON,

Plaintiff,

Case No. 2:07-cv-01509-PMP-PAL

VS.

(Motion for Reversal #20)
(Motion for Remand #25)
(Motion to Strike #28)

MICHAEL J. ASTRUE,
COMMISSIONER OF SOCIAL SECURITY,

Defendant.

FINDINGS AND RECOMMENDATION

This case involves judicial review of administrative action by the Commissioner of Social Security denying Plaintiff Christine Johnson's claim for disability benefits under Title II of the Social Security Act. Plaintiff's Complaint (Dkt. #1) was filed November 14, 2007. Defendant's Answer (Dkt. #15) was filed March 5, 2008, along with a certified copy of the administrative record.¹ This matter has been submitted to the undersigned United States Magistrate Judge for Findings and Recommendations on Johnson's Motion for Reversal (Dkt. #20) filed on May 7, 2008, and the Commissioner's Motion for Remand (Dkt. #25).

BACKGROUND

I. Procedural History.

On April 15, 2003, Johnson filed an application for Social Security Disability Insurance Benefits alleging she became disabled on October 25, 1998. (A.R. 30). Her claim was denied by the Social Security Administration (the “SSA”), and Johnson timely filed a request for a reconsideration hearing before an Administrative Law Judge (“ALJ”) on March 29, 2005. (A.R. 29). The hearing before the Honorable Eve B. Godfrey, the ALJ, was held on June 13, 2006. The ALJ issued her decision on August 25, 2006, finding

¹Exhibit “A” attached to Defendant’s Answer (Dkt. #15) is a certified copy of the entire administrative record in this matter. This Report and Recommendation will refer to Exhibit “A” as the Administrative Record (“A.R.”).

1 Johnson met the non-disability requirements of Section 216(i) of the Social Security Act and was insured
2 for disability benefits through March 31, 2004, but was not disabled within the meaning of the Act. (A.R.
3 29, 30). Johnson requested review of the ALJ's decision by the Appeals Council on October 4, 2006. (A.R.
4 10-11). The Appeals Council denied review of the ALJ's decision on September 12, 2007, making the
5 ALJ's decision the final decision of the Commissioner of Social Security (the "Commissioner"). (A.R. 5 -
6 9).

7 On November 14, 2007, Johnson filed a Complaint (Dkt. #1) in this court, appealing the decision
8 of the Commissioner. The Commissioner filed an Answer (Dkt. #15) to Plaintiff's Complaint on February
9 5, 2008. A Scheduling Order (Dkt. #17) was entered on March 7, 2008. Johnson filed a Motion for
10 Reversal (Dkt. #20) on May 7, 2008, to which the Commissioner responded by filing a Motion to Voluntary
11 [sic] Remand Pursuant to Sentence Four of 42 U.S.C. § 405(g) on July 22, 2008 (Dkt. #25). On August 4,
12 2008, Johnson filed a Reply to Defendant's Motion for Remand (Dkt. #26). On August 19, 2008, the
13 Commissioner filed a Reply (Dkt. #27). On August 27, 2008, Johnson filed a Motion to Strike the Motion
14 to Remand (Dkt. #28). On September 25, 2008, the Commissioner filed a response to the Motion to Strike
15 (Dkt. #29). The Court has considered the Motion for Remand, the Motion for Reversal, Johnson's
16 Response, the Commissioner's Response, the Motion to Strike, the Response to the Motion to Strike, and
17 the Administrative Record below.

18 **II. Facts and Medical Record Below.**

19 Christine Johnson was born on March 14, 1966, has a high school equivalency education, and is a
20 certified diamontologist and gemologist. (A.R. 30). Johnson protectively filed an Application for Disability
21 Insurance Benefits on April 15, 2003 alleging an inability to work since October 25, 1998 (A.R. 29).

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1 Johnson alleges that she became disabled on October 25, 1998 as a result of a combination of medical
 2 impairments consisting of cervical disc disease status post fusion,² lumbar degenerative disease³, status post
 3 right shoulder arthroscopic surgery⁴, and an affective disorder⁵. (A.R. 30, 600). Johnson has also been
 4 diagnosed with osteoarthritis, which has reduced her ability to walk or stand for any length of time. (A.R.
 5 159). Johnson also suffers from chronic neck pain associated with the removal of a disc and fusion of the
 6 bones in her neck, nerve radiculopathy of the right arm, lower lumbar strain, chronic disc disease of the low
 7 back, a fractured coccyx, lower extremity swelling with chronic pain and numbness in the buttocks and legs
 8 and migraine headaches. (A.R. 158 - 161). As a result of these conditions, Johnson has been prescribed
 9 various medications since a May 5, 1994 automobile accident, including, among others, Lortab for lower
 10 back and spinal pain; Flexeril for stiffness, headaches, and muscle pain; Lexapro for depression; Percoset
 11 for pain; Restoril to sleep; and Actonel for treatment of bone loss due to osteoporosis. (A.R. 154, 160). She
 12 claims Flexeril and Percoset make her sleepy, groggy and unable to concentrate. (A.R. 124-125, 154).

13 Prior to her alleged disability, Johnson was employed as a retail store manager, a gate agent for an
 14 airline company, a reservations agent for an airline company, and a salesperson. (A.R. 30). Johnson has
 15 been unable to work a full day since August 1998, although she briefly attempted work as a child care
 16 monitor one day a week between 2000 and 2001. (A.R. 125, 163).

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18 ²Cervical disc disease is characterized by a bulge or rupture of the disc material into the spinal
 19 canal, which causes abnormal pressure on the nerve at that level, leading to symptoms in the neck, arm,
 20 and/or hand. See E-medicine by WebMD, <http://emedicine.medscape.com/article/305720-overview> (last
 21 visited February 26, 2010).

22 ³Syndrome characterized by pain in the lower back, sometimes radiating into the hips and legs.
 23 See Spine-Health, <http://www.spine-health.com/conditions/degenerative-disc-disease/lumbar-degenerative-disc-disease> (last visited February 26, 2010).

24 ⁴Minimally invasive surgical procedure used to visualize, diagnose, and treat torn rotator cuff.
 25 An orthopaedic surgeon makes a small incision in the patient's skin and then inserts pencil sized
 26 instruments containing a small lens and lighting system to magnify and illuminate the structures inside
 27 the shoulder joint. See Hospital for Special Surgery, http://www.hss.edu/conditions_14160.asp (last
 28 visited February 26, 2010).

29 ⁵A mental disorder characterized by dramatic changes or extremes of mood, including manic or
 30 depressive episodes, and often a combination of the two. See Britannica, <http://www.britannica.com/EBchecked/topic/7688/affective-disorder> (last visited February 26, 2010).

1 **A. Onset of Johnson's Alleged Disability.**

2 In May 5, 1994, Johnson was involved in an automobile accident, in which she was rear-ended by
 3 another vehicle. (A.R. 165, 166). Johnson's car was stopped, and she was wearing her seatbelt. (A.R. 170).
 4 Johnson was initially treated at the Lahey Clinic by John J. Foley, M.D. and diagnosed with acute cervical
 5 strain. (A.R. 170, 198). X-rays taken of the cervical spine were normal. (A.R. 198, 200). On June 30, 1994
 6 an MRI examination of the cervical spine revealed a central right-sided disc herniation at the C5-6 level and
 7 material extending along the dorsal aspect of the lower to mid C5 vertebral body raising the possibility of
 8 a free disc fragment. The MRI was ordered by Dr. Fullerton, a neurologist who also prescribed a six-month
 9 course of physical therapy for Johnson. (A.R. 204). Johnson had two Electromyelograms ("EMGs"), the
 10 second of which was consistent with a C6 radiculopathy.⁶ *Id.* An MRI of the cervical spine was performed
 11 October 27, 1994 which found a small midline disc protrusion with no cord compression noted at the C5-6
 12 level and a slight right C5-6 foraminal asymmetry with no apparent nerve root compression. (A.R. 177).
 13 A cervical myelogram performed October 26, 1994 found a small central extradural defect at C5-6 without
 14 nerve root effacement. (A.R. 178). A post myelogram CT of the cervical spine performed October 26, 1994
 15 found a small central and right paramedian disc bulge at C5-6 without spinal canal or nerve root
 16 compromise. (A.R. 179).

17 Johnson saw Dr. McCann, a neurosurgeon with the New England Neurological Associates October
 18 12, 1994. Dr. McCann was referred to the plaintiff by Dr. Fischera. (A.R. 313). Dr. McCann's notes reflect
 19 that Dr. Fullerton and Johnson's physical therapist thought she should be considered for surgery in
 20 September. At the time of the initial visit Johnson was taking Norflex, Flexeril and Motrin 800. On
 21 physical examination Johnson did not appear in any acute distress but had tenderness over the inferior right
 22 cervical spine posteriorly as well as over the right supraclavicular fossa. (A.R. 314). Mild restriction and
 23 rotation of the neck to the right and pain going into the right shoulder and upper arm were observed when
 24 turning the neck to the right and extending the neck. *Id.* Range of motion through the right shoulder was
 25 normal. Dr. McCann's impression was "HNP, C5-6 with right C6 radiculopathy". *Id.* He opined that "the

27 ⁶ Nerve root damage resulting in pain that radiates from the neck and from around the shoulder
 28 into the arm and the forearm. See Radiculopathies, <http://www.neuroanatomy.wisc.edu/SClinic/Radiculo/Radiculopathy.htm> (last visited February 26, 2010).

1 patient's pain syndrome and paresthesiae match a C6 radiculopathy quite well in spite of the lack of
2 objective neurological deficits or EMG confirmatory findings." Id. Dr. McCann agreed that Johnson was
3 a surgical candidate and suspected she would do well with decompression of the right C6 cervical nerve root
4 by either the posterior or anterior approach, although he would favor the latter. Id.

5 Johnson treated with Dr. Edward Fischer, a neurologist at the Boston University Medical Center for
6 persistent right-sided neck and arm pain and discomfort following the May 5, 1994 automobile accident.
7 (A.R. 170). Dr. Fischer's impression was that she had a right C6 radiculopathy secondary to the automobile
8 accident of May 5, 1994. He found that her symptoms fit a right C6 radiculopathy, and that the EMG
9 findings of October 28, 1994 also supported this finding. (A.R. 172). In a consultation on November 9,
10 1994 Dr. Fischer considered Johnson a patient for surgical decompression, but due to her young age
11 prescribed Nortriptyline and a swim program to alleviate her pain. (A.R.172). She was seen by Dr. Fischer
12 in follow-up consultations on December 28, 1994 and February 8, 1995 for symptoms of right C6
13 radiculopathy. (A.R. 166). At that time she was still receiving treatment with a muscle therapist three times
14 per week and taking Elavil which was not effective in controlling her pain. She was also taking 800mgs of
15 Motrin and remained on work disability status. Dr. Fischer increased the dose of Elavil from 50mgs to 75
16 mgs and advised Johnson to continue her swim program and physical therapy exercises. Johnson was
17 referred for a follow-up EMG by Dr. Fischer at the Boston Medical Center Hospital on January 26, 1996.
18 At the time of her examination she was complaining of stiffness in the neck with radiation of pain sensation
19 in the right arm. She indicated improvement of the neck and right shoulder pain but continued pain in her
20 right arm and had recently felt a lump on the left side of her neck with headache behind her left ear. (A.R.
21 165). EMG and nerve conduction studies of the right upper extremity and needle sampling of C5-6 and C6-
22 7 showed evidence of a mild, reinervated right C6 root lesion. Id.

23 On September 14, 1994 Johnson saw Dr. Fullerton complaining of neck pain radiating to the right
24 radial forearm, essentially unchanged since the onset of her May 4, 1994 accident. (A.R. 220). She reported
25 that Norflex 100mgs BID and Motrin 800mgs were helpful. Dr. Fullerton referred her to Dr. David Roth,
26 a microneurosurgeon for additional evaluation as a result of her persistent pain. Id. Dr. Roth first saw
27 Johnson for a neurological consultation on February 17, 1995. (A.R. 214). The patient rated her pain as a
28 7 on a scale of 1 to 10 in severity. Dr. Roth concluded Johnson was experiencing chronic and medically

intractable neck and right arm pain and paresthesias with evidence of a herniated cervical disc by MRI scan and C6 radiculopathy by EMG. (A.R. 214 - 215).

Johnson had a comprehensive visit with Dr. Jules Nazzaro on October 20, 1994 complaining of right-sided neck discomfort radiating to the right suprascapular area and shoulder area and discomfort and paresthesias radiating down her right arm. (A.R. 234 - 235). At the time of the visit she was taking Flexeril three times a day and Norflex three times a day. (A.R. 235). Dr. Nazzaro discussed Johnson's options with her in detail. Johnson stated she felt she had exhausted conservative measures and had been evaluated by an outside neurosurgeon. (A.R. 237). In a follow-up visit on November 1, 1994 Dr. Nazzaro recommended against surgical intervention. (A.R. 230).

On August 12, 1994 Johnson was advised by her physical therapist, James Leonardo, M.S.P.T., not to work for three weeks or until she gained approval from her primary physician as a result of her herniated cervical disc and persistent pain in her neck and arm. (A.R. 287). On November 4, 1994 Leonardo noted that Johnson was reporting pain of 9 on a scale of 1 to 10 following a myelogram and EMG. (A.R. 281). A note in his medical records reflects Dr. Jabrey reported the results of her myelogram, EMG and CT Scan indicating evidence of nerve damage down her right arm and to her fingers. (A.R. 281).

Johnson was first seen by Microneurosurgeon Dr. David Roth on February 7, 1995 at the request of her physical therapist James Leonardo. (A.R. 204). On March 15, 1995 Johnson underwent a cervical analgesic diskography in which Xylocaine was injected at the C5-6 level. (A.R. 249). Prior to the procedure Johnson complained of neck and right shoulder pain with radiation down the right arm. She also complained of tenderness and muscle spasm of the right trapezius and scapular muscles with limitation of motion. Following the Xylocain injection she reported 70% improvement and returned to full range of motion of the neck reporting no arm pain. Tenderness and muscle spasm of the cervical paraspinal muscle also diminished which Dr. Roth found "a positive test at this level." (A.R. 249). On May 4, 1995, Johnson was admitted to Melrose Wakefield Hospital and underwent an anterior cervical microdiscectomy at the C5-6 interspace⁷ (A.R. 242). The procedure was performed by Dr. Roth who found moderately large right-sided gritty,

⁷ The procedure used to remove a herniated disk and relieve pressure on a nerve root. See Spine Inc., <http://www.spine-inc.com/glossary/d/discectomy.html> (last visited February 26, 2010).

1 granular disc prolapse extending into the intervertebral foramen and slightly above it, surrounded by
2 moderate amounts of granulation tissue. He also found small marginal osteophytes at that level. He
3 performed a fusion and discharged Johnson with prescriptions for Percoset, and Decadrin followed by
4 Motrin. (A.R. 242).

5 Following her discectomy and fusion, Johnson was prescribed more physical therapy for pain in her
6 neck and soreness at the area of the right C6-7 and a constant burning sensation in her right upper arm and
7 forearm. (A.R. 266-289). Six weeks post-surgery her arm improved but she complained of residual
8 numbness and a recent onset of paresthesias in the left arm and hand after sleeping. She was taking Motrin
9 and Elavil for pain. (A.R. 277). Four months post-operatively she complained of continuing neck pain
10 radiating to the right shoulder and upper arm, pain at the left side of the neck causing occasional headaches.
11 On examination she exhibited moderate spasm and tenderness of the left paraspinal and right trapezius
12 muscles. She was prescribed continued physical therapy with limited repetitive motions of the right upper
13 arm and Soma. (A.R. 277).

14 On January 9, 1996 Dr. Roth allowed Johnson to return to work no more than twenty hours per week.
15 (A.R. 207). Restrictions imposed at that time consisted of: (a) no repetitive neck movements; (b) no
16 prolonged neck flexion or extension; (c) no heavy lifting; and (d) no lifting above the shoulders or working
17 above shoulder height. (A.R. 207 - 209). On February 6, 1996 Dr. Roth provided his medical opinion that
18 Johnson was not currently able to return to her previous full-time occupation because of the physical
19 demands and emotional distresses involved with the position. At that time Johnson continued to experience
20 chronic headaches, neck pain and arm discomfort. She was working twenty hours per week and being seen
21 by Dr. Popovich, a pain specialist for active management of her chronic pain syndrome. (A.R. 207).

22 On March 11, 1996 Dr. Roth opined that Johnson had a permanent partial disability as a result of
23 injuries sustained in the May 5, 1994 automobile accident. He diagnosed Johnson with a right C5-6
24 herniated disc with C6 nerve root compression. (A.R. 205). He concluded Johnson had reached a medical
25 end result and that it was probable she would continue to experience episodic neck and arm pain and
26 headaches and would need symptomatic medical care for these complaints. Id. He opined that Johnson was
27 totally disabled from August 26, 1994 to October 16, 1995. (A.R. 204 - 206). He based his opinions on
28 AMA Guides to the Evaluation of Permanent Impairment, Fourth Edition (1993) indicating Johnson had

1 experienced the loss of function rated in terms of impairment of the whole person as follows: (1) cervical
 2 spine surgically treated disc lesion with residual medically documented pain and rigidity with muscle spasm
 3 rated at 9%; (2) abnormal range of motion of the cervical spine rated at 4%; (3) C6 unilateral spinal nerve
 4 root involvement with sensory deficit, extremity pain and loss of strength rated at 6% for a combined 18%
 5 whole person impairment. (A.R. 206).

6 In November 1995 Johnson began treating with Dr. Brana Popovich, a pain management specialist.
 7 She was referred to the Pain Diagnostics and Rehabilitation Clinic by Dr. Fichera for evaluation and
 8 treatment of persistent neck, shoulder and right arm pain. (A.R. 410). Johnson complained of pain in both
 9 shoulders, primarily on the right side in the suboccipital region with severe headaches and pain radiating
 10 from right shoulder down to the right upper extremity. Id. During the initial consultation on November 13,
 11 1995 Johnson was taking Flexeril, Elavil and Motrin. Dr. Fichera referred her to the clinic recommending
 12 treatment of myofascial trigger points for severe headaches and pain radiating from her right shoulder down
 13 to her right upper extremity. (A.R. 410). Dr. Popovich diagnosed her with status-post surgical
 14 decompression of C6 nerve root and myofascial pain syndrome⁸ with trigger points. She began
 15 administering lidocaine injections and recommended additional physical therapy treatment followed by a
 16 spray and stretch technique and stretching exercises. (A.R. 411). Johnson continued to treat with Dr.
 17 Popovich through June 11, 1997. (A.R. 379). She complained of headaches at time very severe and
 18 persistent neck, shoulder and right arm pain throughout her course of treatment. (A.R. 379-415). She was
 19 prescribed Imitrex, Elavil, Motrin 800, Cataflam and Flexeril to relieve the pain during her course of
 20 treatment with Dr. Popovich. (A.R. 390).

21 In the spring of 1996, Johnson visited with Tad S. Davis, M.D., a Certified Psychologist, who
 22 diagnosed her with major depressive disorder and chronic pain syndrome resulting from her inability to
 23 control and manage the pain in her back. (A.R. 191). Johnson had gone back to work on a part-time basis
 24 as an airline ticketing agent and reported that this helped her morale and decreased her social isolation but
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26 ⁸ A chronic form of muscle pain that centers around the sensitive points in muscles called trigger
 27 points. Myofascial pain caused by trigger points has been linked to many types of pain, including
 28 headaches, jaw pain, neck pain, low back pain, pelvic pain, and arm and leg pain. See MayoClinic.com,
<http://www.mayoclinic.com/health/myofascial-pain-syndrome/DS01042> (last visited February 26, 2010).

1 the increase in activity worsened her chronic pain. (A.R. 190). Dr. Davis prescribed Ambien for sleep,
2 Zoloft for depression, and Voltaren for back pain. (A.R. 191). Dr. Davis opined that Johnson's chronic pain
3 and depression were a direct result of injuries sustained in the automobile accident in 1994 and
4 recommended that she participate in an intensive chronic pain management program. (A.R. 192). However,
5 as of April 1996 Johnson had exhausted her rehabilitation benefit and could not afford the recommended
6 treatment. (A.R. 192).

7 **B. Johnson's Subsequent Injuries.**

8 On June 29, 1997, Johnson suffered an injury while pushing a wheelchair at work, resulting in a
9 sprain/strain to her left sacroiliac joint. (A.R. 301). The sprain/strain was further exacerbated by Johnson's
10 pregnancy, as well as the prolonged sitting resulting from her commute and sedentary job. (A.R. 301). Her
11 initial response to treatment was as expected and she noted immediate reduction in pressure and felt looser.
12 She reported improvement with subsequent visits. Id. John M. Rice, D.C. at the Merrimack Chiropractic
13 Center opined that the one to two hour commute to her job, eight hours of prolonged sitting at work, and her
14 pregnancy caused further postural stress to her low back and that a combination of these factors made it
15 impossible to stabilize the initial injury. Id. Her condition had become more chronic. Johnson reported
16 improvement with time away from work, but a return of symptoms when she returned to her normal duties.
17 She planned on taking ten days off to see if return to work was possible. Id. Rice advised her to avoid return
18 to work until after her delivery if her symptoms returned. Id. Johnson received physical therapy from St.
19 Joseph Family Medical Center/Hospital beginning July 3, 1997, as a result of this injury, and was prescribed
20 a period of physical therapy for a condition diagnosed as pelvic torsion. (A.R. 325 - 327).

21 On August 26, 1998 the plaintiff was in another automobile accident. She was a passenger in a car
22 and was turning to look back at her baby when the accident happened and she felt her neck "pop". She was
23 treated in the emergency room at Saints Memorial Medical Center for neck and knee pain. An x-ray of her
24 right knee was negative. An x-ray taken of the cervical spine indicated a fusion present with no
25 abnormalities or soft tissue swelling. She was prescribed ice and heat treatments and advised to follow-up
26 with her primary physician. (A.R. 254 - 258).

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In March 1999, Johnson was treated for lumbar strain syndrome. (A.R. 422). She reported tenderness in the sacroiliac area on the left side, consistent with a sacrioliitis.⁹ (A.R. 422). In June 1999 a liver lesion was discovered in a CAT Scan. She was seen by Dr. Richard Freeman at the New England Medical Center to discuss treatment for her liver lesion. (A.R. 311). She was asymptomatic, and due to the lack of any symptoms attributable to this lesion she was advised to have a follow-up CAT Scan in six to twelve months and to discontinue oral contraceptives. Id. Dr. Freeman also noted trace ankle edema during his physical examination and suggested a work-up with an MR angiogram.

In September 2002, Johnson broke her right shoulder when she fell and landed with her arm extended to break her fall. (A.R. 474). The injury caused pain and weakness, clicking, and it limited Johnson's range of motion. (A.R. 456, 474). In December 2002, Johnson underwent an arthroscopic subacromial decompression¹⁰ as well as a debridement¹¹ for a partial thickness rotator cuff tear in her right shoulder. (A.R. 368, 456-57).

On July 8, 2003, Johnson was involved in another automobile collision. (A.R. 151). Johnson's car was rear-ended by another automobile, and as a result of this accident, Johnson suffered severe lower back pain, whiplash, and she reinjured her pre-existing cervical spine injury. (A.R. 151). She was seen by Dr. Douglas Goumas at the Orthopaedic Center on August 6, 2003 complaining of low back pain. Dr. Goumas noted that she was treated by her primary care physician for immediate low back pain experienced during the accident with a Medrol Dose Pak. (A.R. 367). In her visit with Dr. Goumas she reported that she was doing fine until several weeks after the accident when she tried to get out of a pool and felt her legs going numb for several seconds. Id. On physical examination she demonstrated some pain to palpation around

⁹ An inflammation of one or both sacroiliac joints (those joints that connect the lower spine and pelvis). With sacrioliitis, even slight movements of the spine can be uncomfortable or painful. See MayoClinic.com, <http://www.mayoclinic.com/health/sacrioliitis/DS00726> (last visited February 26, 2010).

¹⁰ Arthroscopic surgery used to treat debridement of partial and full tears of a rotator cuff. See <http://www.ortho-md.com/subacromial%20decompression.htm> (last visited February 26, 2010).

¹¹ Term referring to the removal of dead, damaged, or infected tissue to improve the healing potential of the remaining healthy tissue. See Aurora Health Care, <http://www.aurorahealthcare.org/yourhealth/healthgate/getcontent.asp?URLhealthgate=%2214803.html%22> (last visited February 26, 2010).

1 the paralumbar musculature especially over the left side. The doctor also noted pain with extension and
2 minimal pain with flexion. Neurologically her extremities were in tact and no motor or sensory deficits were
3 noted. The straight leg test was negative. X-rays demonstrated some arthritic changes of the posterior
4 elements, but nothing severe. Dr. Goumas diagnosed her with low back strain with some nerve root
5 irritation and treated her conservatively. Id. On September 11, 2003 Johnson was seen in a follow-up visit
6 for low back pain. A straight leg test was positive for pain in the low back with no radiculopathy. An MRI
7 demonstrated some degenerative changes at L5-S1 but was otherwise negative. Dr. Goumas referred her
8 to Dr. Lewis and Leahy for a work-up concerning her back pain. (A.R. 366).

9 Between 1998 and 2004, Johnson was treated by Bedford Family Practice and Ambulatory Surgical
10 for various ailments, including chronic neck pain, status post microdiscectomy, chronic back pain secondary
11 to degenerative disc disease, headaches, depression, and right rotator cuff tear with impingement status post
12 arthroscopic subcromial decompression with extensive debridement. (A.R. 427-479).

13 At the request of the Social Security Administration Johnson was seen by Miles S. Morgan, a clinical
14 psychologist who conducted a mental status examination on February 5, 2004. (A.R. 17, 480). Dr. Morgan
15 noted that Johnson was able to maintain an upright posture while sitting for the examination but did appear
16 to be experiencing physical pain. (A.R. 4870). She became tearful when describing the nature of her
17 disability, and related her automobile accidents in 1994, 1998 and 2003. Id. She moved to Las Vegas in
18 November 2003 because her doctors in New Hampshire believed the dry climate would decrease her chronic
19 pain. (A.R. 481). She reported being diagnosed with depression in 2003 in New Hampshire. Id. Her
20 current medications included Lexipro, Flexeril, Imitrex, and Ambien. Id. She also reported that she was
21 attempting to limit her pain medication because she became so tired she was unable to adequately care for
22 her children. Id. However, this caused chronic pain throughout the day. Id. On mental status examination
23 Dr. Morgan concluded that she did not have any significant deficits with intellectual functioning. (A.R.
24 483). She did not display any significant memory deficits, and all of her scores were within the average to
25 high average range. (A.R. 484). However, on functional assessment Dr. Morgan found that she was likely
26 functioning minimally within the average range of intellectual ability and that it was likely she experienced
27 decline with cognitive functioning when taking pain medication. Id. He found that she did not demonstrate
28 depressive symptoms at a level that would significantly interfere with her ability to understand or remember

1 complex instruction. Id. However, he noted she becomes easily distressed when discussing her physical
2 limitations and found she would likely have some difficulty sustaining social interactions within a work
3 setting. Id. He diagnosed her with a mood disorder due to back injury. Id. Because she had experienced
4 no reported improvements with pain or physical functioning following treatment after her 1994 automobile
5 accident he concluded her depression had persisted and that she should be assessed by a psychiatrist to
6 ensure she is taking the appropriate type and dose of medication. Id. He opined that her prognosis for
7 significant recovery from depressive symptoms would be dependent on her response to medical intervention,
8 and that her depression appeared to be directly related to the onset of medical problems. (A.R. 484 - 485).

9 On February 20, 2005, Johnson was involved in another accident. (A.R. 536). While loading
10 groceries into her car, another vehicle reversed from its parking spot and pinned her to the bumper of her
11 car. Id. She was taken to the hospital by ambulance. Id. She was seen at Las Vegas Neurosurgery,
12 Orthopaedics & Rehabilitation, LLP by Dr. Mark B. Kabins, complaining of pain in her neck, low back pain
13 with aching stiffness and numbness in her left leg down the back of her leg to the foot. Id. She claimed to
14 experience immediate pain after the accident and was initially seen by Dr. Loring and Dr. Jacobs. Id. At
15 the time of her visit with Dr. Kabins she complained of pain of a 10 on a scale of 1 - 10. Id. She reported
16 she could only sit three to four minutes, stand three to four minutes, lie down five minutes at a time and that
17 her walking distance was six feet. Id. She complained that she woke up many times at night from pain and
18 was unable to do her household chores and daily activities although she was able to drive. Id.

19 At the time of her July 11, 2005 visit with Dr. Kabins she was taking Lortab, Flexeril, Mobic,
20 Ambien, and Imitrex. Radiographs and testing performed revealed a C-spine lateral flexion/extension with
21 no gross evidence of instability, abnormal motion or translation. AP and lateral radiograph of the
22 lumbosacral spine demonstrated disc space narrowing at L5-S1 with lateral flexion/extension views
23 demonstrating foraminal stenosis, particularly at the L5-S1. An MRI scan of the lumbosacral spine
24 demonstrated a central disc protrusion at L5-S1 level with disc dehydration. Id. On physical examination
25 Johnson demonstrated a well healed anterior neck incision, mild restrictive neck range of motion with no
26 neurologic deficit in her upper extremities. (A.R. 538). With respect to her low back, she could bend
27 forward only 40 degrees and extend just beyond neutral. Id. She had a positive straight leg raise and
28 Lasegue's sign on the left and was negative on the right. Id. She had decreased sensation in the L5

1 distribution on the left. Id. Dr. Kabins diagnosed Johnson with a herniated nucleus pulposus L5-S1 with
 2 a possible disc disruption at L5-S1¹². Id. He also diagnosed low back pain with left lower extremity
 3 radiculopathy. Id. He gave Johnson a prescription for Restoril for sleeping at night and ordered electrical
 4 diagnostic studies of the lower extremities. Id. He also recommended physical therapy including low back
 5 reconditioning, abdominal strengthening and pelvic stabilization. Id. He found a left L5 and S1 selective
 6 nerve root block was indicated, and directed Johnson to return in three weeks for follow-up. Id.

7 An MRI of the lumbar was taken at Diagnostic Imaging of Southern Nevada on April 11, 2005. The
 8 MRI revealed a broad-based central disc protrusion without significant central canal stenosis or nerve root
 9 compression at L5-S1 and mild facet degeneration at the L4-L5 and L5-S1 levels. (A.R. 550).

10 Dr. Kabins referred Johnson to Michael J. McKenna, M.D., FIPP, at the Interventional Pain Medicine
 11 of Nevada. She was first seen by Dr. McKenna on August 1, 2005 complaining of pain in her back
 12 extending into her left lower extremity following her February 2005 pedestrian versus motor vehicle
 13 accident. (A.R. 553). She complained of aching, stabbing and constant pain and rated it an 8 up to 9 on a
 14 scale of 10 which increased with transitioning from sitting to standing, prolonged sitting, prolonged standing
 15 and walking. Id. She denied pain in her right lower extremity. Id. The pain in her left extremity extended
 16 into the left foot and most significantly into the left big toe. Id. She was taking Lortab and Mobic. Id. On
 17 physical examination Dr. McKenna noted her gait was antalgic favoring the left leg. (A.R. 554). A straight
 18 leg test was positive on the left and negative on the right. Id. Lasegue's sign was positive on the left. Id.
 19 He noted decreased sensation of the lateral and posterior aspect of the left leg and the dorsum of the left foot.
 20 Id. Deep tendon reflexes were symmetric and motor strength intact. Id. Bending forward caused her pain
 21 at 45 degrees. Id. Her extension was full and her hip external rotation did not cause pain. Id. Dr. McKenna
 22 assessed her with left lower extremity radiculopathy and evidence of L5-S1 disc pathology. Id. He
 23 considered her a candidate for transforaminal epidural injection to attempt symptomatic relief. Id. He
 24 opined that if injection was ineffective Johnson may be a candidate for provocation discography. Id.

25 On August 23, 2005 Dr. McKenna performed a selective transforaminal epidural steroid injection
 26 under local anesthesia at the left L5, L5-S1 neuroforamina area. He also performed an Epidurography,

27 28 ¹² The medical term for a herniated or slipped disc. See Medscape, from WebMD,
http://www.medscape.com/viewarticle/512033_3 (last visited February 26, 2010).

1 Fluroscopy, and X-ray of the lumbar spine. Under conscious sedation, Lidocaine and Methylprednisolone
 2 were injected. (A.R. 547-48).

3 The plaintiff treated with Jacobs & Modaber, M.D.s beginning February 6, 2006. Bone density and
 4 vertebra assessments were performed which revealed Osteopenia in the lumbar, hips and forearm areas.
 5 Scans were performed of the lumbar spine and left hip. (A.R. 522 - 527).

6 On July 21, 2004, May 10, 2006 and September 5, 2006, Dr. Roth opined that Johnson became
 7 totally and permanently disabled beginning on October 27, 1997. (A.R. 202, 540). He diagnosed her with:
 8 "(a) herniated cervical disc followed by cervical fusion and residual permanent nerve damage; (b)
 9 fibromyalgia; (c) myofascial pain syndrome; (d) lumbar discogenic degenerative disease with pain; (e) L5-
 10 S1 disc herniation; (f) osteoporosis in the hips, spine, and forearm." (A.R. 541). As a result of these
 11 diagnoses, Dr. Roth concluded Johnson was totally and permanently disabled for any kind of employment.
 12 (A.R. 541).

13 **DISCUSSION**

14 **I. Standard of Review**

15 Johnson seeks judicial review of the Commissioner's decision determining that she was not eligible
 16 to receive disability insurance benefits. Johnson timely requested review by the Appeals Council which
 17 declined her request for review on September 12, 2007. When the Appeals Council denies a request for
 18 review of an ALJ's decision, the decision of the ALJ represents the final decision of the Commissioner. See
 19 20 C.F.R. § 404.981. Johnson then filed this action seeking judicial review of the Commissioner's decision.
 20 See 20 CFR § 404.901(a)(5); 42 U.S.C. § 405(g). This matter was referred to the undersigned for a report
 21 of findings and recommendations pursuant to the provisions of 28 U.S.C. §§ 636 (b)(1)(B) and (C).

22 District courts review administrative decisions in social security benefits cases under 42 U.S.C. §
 23 405(g). See *Akopyan v. Barnhart*, 296 F.3d 852, 854 (9th Cir. 2002). The statute provides, in relevant part,
 24 that "[a]ny individual, after any final decision of the Commissioner of Social Security made after a hearing
 25 to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by
 26 a civil action . . . brought in the district court of the United States for the judicial district in which the
 27 plaintiff resides." 42 U.S.C. § 405(g).

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1 42 U.S.C. § 405 (g) provides that the District Court may enter, “upon the pleadings and transcripts
 2 of the record, a judgment affirming, modifying, or reversing the decision of the Commissioner of Social
 3 Security, with or without remanding the cause for a rehearing.” The Ninth Circuit reviews a decision of a
 4 District Court affirming, modifying or reversing a decision of the commissioner *de novo*. Batson v.
 5 Commissioner 359 F.3d 1190, 1193 (9th Cir. 2003).

6 The Commissioner’s findings of fact are conclusive if supported by substantial evidence. 42 U.S.C.
 7 § 405(g). The Commissioner’s findings may be set aside if they are based on legal error or are not supported
 8 by substantial evidence. Smolen v. Chater, 80 F.3d 1273, 1279 (9th Cir. 1996). The Ninth Circuit defines
 9 substantial evidence as “more than a mere scintilla but less than a preponderance; it is such relevant evidence
 10 as a reasonable mind might accept as adequate to support a conclusion.” Andrews v. Shalala, 53 F.3d 1035,
 11 1039 (9th Cir. 1995); see also Lewis v. Apfel, 236 F.3d 503 (9th Cir. 2001). In determining whether the
 12 Commissioner’s findings are supported by substantial evidence, the court “must review the administrative
 13 record as a whole, weighing both the evidence that supports and the evidence that detracts from the
 14 Commissioner’s conclusion.” Reddick v. Chater, 157 F.3rd 715, 720 (9th Cir. 1998); see also Smolen, 80
 15 F.3d at 1279 (holding that courts must weigh both the evidence that supports and the evidence that detracts
 16 from the Commissioner’s conclusion). Under the substantial evidence test, the Commissioner’s findings
 17 must be upheld if supported by inferences reasonably drawn from the record. Batson 359 F.3d at 1193.
 18 When the evidence will support more than one rational interpretation, the court must defer to the
 19 Commissioner’s interpretation. Id. If the evidence can reasonably support either affirming or reversing the
 20 ALJ’s decision, the court may not substitute its judgment for the ALJ’s judgment. Flaten v. Sec’y of Health
 21 and Human Serv., 44 F.3d 1453, 1457 (9th Cir. 1995).

22 It is incumbent on the ALJ to make specific findings so that the court need not speculate as to the
 23 findings. Lewin, 654 F.2d at 635 (citing Baerga v. Richardson, 500 F.2d 309 (3rd Cir. 1974)). In order to
 24 enable the court to properly determine under 42 U.S.C. § 405(g) whether the Commissioner’s decision is
 25 supported by substantial evidence, the ALJ’s findings “should be as comprehensive and analytical as feasible
 26 and, where appropriate, should include a statement of subordinate factual foundations on which the ultimate
 27 factual conclusions are based.” Lewin, 654 F.2d at 635.

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1 **II. Disability Evaluation Process**

2 To qualify for disability benefits under the Social Security Act, a claimant must show that:

- 3 (a) she suffers from a medically determinable physical or mental impairment that can be
4 expected to result in death or that has lasted or can be expected to last for a continuous period
5 of not less than twelve months; and
- 6 (b) the impairment renders the claimant incapable of performing the work that the
7 claimant previously performed and incapable of performing any other substantial
8 gainful employment that exists in the national economy.

9 Tackett v. Apfel, 180 F.3d 1094, 1098 (9th Cir. 1999); see also 42 U.S.C. § 423(d)(2)(A). The claimant has
10 the initial burden of proving disability. Roberts v. Shalala, 66 F.3d 179, 182 (9th Cir 1995), cert. denied,
11 517 U.S. 1122 (1996). To meet this burden, a claimant must demonstrate an “inability to engage in any
12 substantial gainful activity by reason of any medically determinable physical or mental impairment which
13 can be expected . . . to last for a continuous period of not less than 12 months.” 42 U.S.C. § 423(d)(1)(A).
14 If a claimant establishes an inability to perform her prior work, the burden shifts to the Commissioner to
15 show that the claimant can perform other substantial gainful work that exists in the national economy.
16 Batson, 157 F.3d at 721.

17 A plaintiff seeking Social Security disability benefits is also required to prove that he or she became
18 disabled on or before his or her date last insured (“DLI”). Flaten v. Sec’y of Health & Human Serv., 44 F.3d
19 at 1458-1459; see also 20 C.F.R. § 404.1520; Morgan v. Sullivan, 945 F.2d 1079, 1080 (9th Cir. 1991) (*per
curiam*). To qualify for social security disability benefits, a claimant must be fully insured and have at least
21 twenty quarters of coverage in the forty-quarter period which ends in with the quarter in which the disability
22 occurred. See 42 U.S.C. §§ 416(i)(3), 423(c)(1); 20 C.F.R. § 404.130(b). “[T]estimony from family,
23 friends, and neighbors are all relevant to the determination of a continuously existing disability with onset
24 prior to expiration of insured status.” Flaten, 44 F.3d at 1461 n.5 (citing Hartman v. Bowen, 636 F. Supp.
25 129 (N.D. Cal. 1986)). The requirement that an individual seeking benefits be insured at the time the
26 individual suffers the disability is intended to “encourage individuals who have previously suffered from
27 a disability to return to substantial gainful employment when their medical condition improves sufficiently
28 to allow them to do so.” Flaten, 44 F.3d at 1459 (citing S. Rep. No. 1856, 86th Cong., 2d Sess. (1960),

1 reprinted in 1960 U.S.C.C.A.N. 3608, 3623-3625). The ALJ found, and it is undisputed, that Johnson meets
2 the non-disability requirements of Section 216(i) of the Social Security Act and was insured for disability
3 benefits through March 31, 2004.

4 **A. Five-Step Sequential Evaluation Process**

5 20 C.F.R. § 416.920 establishes a five-step sequential evaluation process to be followed by the ALJ
6 in a disability case. Mendoza v. Apfel, 88 F. Supp. 2d 1108, 1111 (C.D. Cal. 2000). The first step requires
7 the ALJ to determine whether the claimant is currently engaged in substantial gainful activity. 20 C.F.R.
8 416.920(b). If the claimant is currently engaged in substantial gainful activity, a finding of non-disabled is
9 made, and the claim is denied. The second step requires the ALJ to determine whether the claimant has a
10 severe impairment or combination of impairments that significantly limit him or her from performing basic
11 work activities. 20 C.F.R. § 416.920(c)). If the ALJ determines that the claimant has no such impairment,
12 a finding of non-disabled is made and the claim is denied. The third step requires the ALJ to compare the
13 claimant's impairment(s) with those impairments in the Listing of Impairments ("Listing") located at 20
14 C.F.R. § 404, Subpart P, Appendix 1. 20 C.F.R. § 416.920(d). If the impairment(s) meets or equals an
15 impairment in the Listing, disability is conclusively presumed and benefits are awarded.

16 If the impairment(s) do not meet or equal an impairment in the Listing, step four requires the ALJ
17 to determine whether the claimant has sufficient residual function capacity ("RFC") despite her
18 impairment(s), to perform her past work. 20 C.F.R. § 416.920(e). RFC assessment is a function-by-function
19 assessment based upon all of the relevant evidence of an individual's ability to do work-related activities.
20 Social Security Administration, Titles II and XVI: Assessing Residual Functional Capacity in Initial Claims,
21 SSR 96-8p, 1996 SSR LEXIS 5, *8. If the claimant is still capable of performing her past work, a finding
22 of non-disabled is made and the claim is denied. The claimant has the burden of proving that she cannot
23 perform her past work. Reddick v. Chater, 157 F.3d 715, 721 (9th Cir. 1998). If the claimant cannot
24 perform her past work, a *prima facie* case of disability is established and step five shifts the burden to the
25 ALJ to prove that the claimant, based on her age, education, work experience, and RFC, can perform other
26 substantial gainful work that exists in significant numbers in the national economy. 20 C.F.R. § 416.920(f).
27 If the ALJ finds that any one of the five steps establishes that the claimant is not disabled, no further
28 evaluation is required. 20 C.F.R. § 404.1520(a).

1 Here, the ALJ determined at step one that Johnson has not engaged in substantial gainful activity
 2 since the alleged onset date of her disability, October 25, 1998.¹³ (A.R. 30). At step two, the ALJ found that
 3 Johnson had the following medically determinable impairments that are severe within the meeting of the
 4 Social Security Act: cervical disk disease status post fusion, lumbar degenerative disease, status post right
 5 shoulder arthroscopic surgery, and an affective disorder. Id. The ALJ found that these impairments imposed
 6 more than minimal restrictions on her ability to engage in basic work-related functions, and that she has
 7 “severe” impairments within the meaning of the Regulations, specifically 20 CFR § 404.1523. Id. At step
 8 three, the ALJ found Johnson’s impairments do not meet or equal any of the impairments in the Listings
 9 because no examining or treating doctor has mentioned findings equivalent in severity to the criteria of any
 10 of the listed impairments. Id. She also relied on the state agency medical consultants’ (not identified in the
 11 decision) conclusions that Johnson’s condition did not meet or equal any listed impairment. Id. Her
 12 decision also stated that Dr. Schorn, an independent medical expert she called at the hearing, testified that
 13 Johnson’s impairments did not meet or equal any listed impairment. Id.

14 At step four, the ALJ determined that Johnson had not met her burden of proving that she cannot
 15 perform her past relevant work. (A.R. 30-31). The ALJ examined whether Johnson retains the residual
 16 functional capacity (“RFC”) to perform the requirements of her past relevant work or other work existing
 17 in significant numbers in the national economy. RFC is defined in the Regulations as the most an individual
 18 can still do after considering the effects of physical and/or mental limitations that affect the ability to
 19 perform work-related tasks. 20 C.F.R. § 404.1545 and Social Security Ruling 96-8(p). The ALJ found that
 20 prior to Johnson’s date last insured (March 31, 2004), Johnson retained the RFC to perform sedentary level
 21 work either with mild limitation in sustaining attention or simple, repetitive tasks with minimal interaction
 22 with the public and a sit/stand option. (A.R. 32). She based this decision on Dr. Roth’s April 14, 2003
 23

24
 25 ¹³The Plaintiff alleges she became disabled on October 25, 1998. (A.R. 30). See also Plaintiff’s
 26 Complaint ¶ 5. Defendant’s Answer admitted the allegations in Paragraph 5 of Plaintiff’s Complaint.
 27 See Answer (#15) ¶ 5. The ALJ’s decision also indicates that Plaintiff alleges she became disabled on
 28 October 25, 1998. (A.R. 30). However, the third paragraph of Page 2 of her decision states “no
 evidence has been presented to indicate that the Claimant has engaged in substantial gainful activity after
 her January 30, 2004 alleged disability onset date.” Nothing in the administrative record supports a
 finding of a January 30, 2004 disability onset claim.

1 report indicating he had been treating Johnson since 1995 for a herniated disc for which she underwent
2 surgery and chronic degenerative lumbar disc disease.

3 She also relied on treatment notes from the Bedford Family Practice and Ambulatory Surgical dated
4 September 1998 to January 2004 showing Johnson was evaluated and treated for complaints of chronic neck
5 pain status post microdiscectomy and chronic back pain secondary to degenerative disc disease, headaches,
6 depression, right rotator cuff tear with impingement status post arthroscopic subcromial decompression and
7 extensive debrievement in 2002. She cited treatment notes from the Orthopedic Center-Manchester dated
8 September 10, 1998 to September 11, 2003 showing Johnson was evaluated and treated for complaints of
9 right shoulder pain status post right shoulder arthroscopic surgery with good results, chronic neck low back
10 pain secondary to degenerative disc disease, and occasional numbness and tingling down the left lower leg,
11 but Johnson denied numbness or weakness. The ALJ specifically referred to x-rays taken August 6, 2003,
12 straight-leg raising tests conducted September 11, 2003, and an MRI of the lumbar spine demonstrating
13 degenerative changes at L5-F1 which was otherwise negative.

14 The ALJ also referred to Dr. Miles Morgan's consultative psychological examination on February
15 5, 2004 which diagnosed Johnson with a mood disorder due to her back injury, and reported her global
16 assessment functioning ("GAF") as sixty-five, suggesting mild symptoms, but generally acceptable function.
17 Finally, she relied upon some, but not all, of Dr. Schorn's testimony at the hearing. She found that Dr.
18 Schorn testified that from his thorough review of the medical record, Johnson has the severe physical
19 impairments of cervical disc disease status post fusion, lumbar degenerative disc disease, and status post
20 right shoulder arthroscopic surgery. The ALJ's understanding of Dr. Schorn's testimony was that there was
21 little objective evidence to support the claimant's disabling conditions. The ALJ acknowledged that Dr.
22 Schorn testified that if one believed all of her pain and suffering really exists, then a somatoform listing
23 would be met. However, she did not accept this testimony on the grounds Dr. Schorn's duty at the hearing
24 was to opine on the medical evidence and not to evaluate the claimant's demeanor (A.R. 31-32).

25 The ALJ found that mentally, Johnson has mild limitation of activities of daily living; moderate
26 difficulties in maintaining social functioning precluding work involving more than minimal interaction with
27 the public; moderate limitations of concentration, persistence, or pace; and no episodes of decompensation.
28 The ALJ gave the State agency medical consultant's findings that Johnson could perform sedentary work

1 activity with additional non-exertional limitations less weight than they would ordinarily receive because
2 they were prepared without the benefit of observing Johnson, listening to her testimony, or reviewing later
3 medical evidence that was submitted. She found the opinions of the State agency medical consultants who
4 examined Johnson's mental condition to be generally consistent with the objective evidence of record for
5 the period at issue.

6 In assessing Johnson's RFC, the ALJ addressed Johnson's allegations of disabling pain and
7 functional limitations pursuant to the law of the Sixth Circuit Court of Appeals and Social Security Rulings
8 96-3p and 96-7p. (A.R. 33). The decision does not indicate why she relied on Sixth Circuit law rather than
9 Ninth Circuit law, or cite any Sixth Circuit decisions. She found that Johnson's subjective allegations were
10 not fully credible by clear and convincing evidence for a number of reasons. First, the opinions of Plaintiff's
11 treating chiropractor, John Rice, DC, were not medically acceptable sources; Rice did not provide objective
12 medical evidence to support his opinions; his limited RFC findings seemed contradicted by his lack of
13 progress notes; and viewing the objective medical evidence of record, his opinion of Johnson's limitations
14 was a conclusion based mostly upon Johnson's subjective complaints rather than objective evidence.
15 Second, she relied on Dr. Schorn's testimony at the hearing "that there is little objective evidence to support
16 any of the claimant's disabling conditions." Id. Third, She found Johnson contradicted her own testimony
17 about whether or not she did or did not drive. Fourth, she found Johnson's treatment "has been relatively
18 conservative.". Fifth, she found Johnson had not been taking any medications that imposed disabling side
19 effects or medications at dosages commensurate with the alleged levels of pain. Sixth, she found the record
20 did not indicate that Johnson suffers from debilitating side effects from her medications. Seventh, she found
21 no treating or examining physician has opined that Johnson is totally and permanently disabled from all
22 work. Eighth, she found Johnson was able to participate in the administrative hearing and respond to
23 questioning without any apparent difficulties. Ninth, she found that Johnson described her activities of daily
24 living which were not limited to the extent one would expect given Johnson's complaint of disabling
25 symptoms and limitations. Tenth, she found Johnson was apparently able to care for young children at
26 home, which can be quite demanding both physically and emotionally, with only some assistance. Id. Thus,
27 she concluded that Johnson's allegations of disabling functional limitations were not fully credible, and that
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1 neither the objective medical evidence nor Johnson's subjective allegations "warrant any more restrictive
 2 functional limitations than those which are found in this case". Id.

3 Additionally, the ALJ considered the report of Johnson's mother, Kay Hoover, finding it did not
 4 establish that Johnson is disabled. She based her finding on the fact that Ms. Hoover was not medically
 5 trained and, that as Johnson's mother, Ms. Hoover "cannot be considered a disinterested third-party
 6 witness." Most importantly, the ALJ found that significant weight could not be given to Ms. Hoover's report
 7 because her report, like Johnson's reports and testimony, were not consistent with the preponderance of the
 8 opinions and observations by medical doctors in this case. (A.R. 34).

9 The ALJ found at step four that Johnson retains the RFC to perform the requirements of her past
 10 relevant work as a reservations clerk. Id. She based this finding on the expert vocational testimony provided
 11 at the hearing by Alan Cummings, PhD. She posed a hypothetical question to Mr. Cummings, which she
 12 believed assumed Johnson's age, education, past relevant work experience, and RFC as she had found. Her
 13 reading of Mr. Cummings' testimony was that, given the hypothetical posed, Johnson would not be able to
 14 perform her past relevant work as a retail store manager, gate agent or sales person. Id. The ALJ agreed
 15 with his analysis and so found. Id. She also found that Mr. Cummings testified that prior to March 31,
 16 2004, Johnson retained the RFC to perform sedentary level work with mild limitation in sustaining attention,
 17 and could return to her past relevant work as a reservation clerk. Id. The ALJ therefore found Johnson had
 18 "consistently retained the residual functional capacity to perform her past relevant work as a reservations
 19 clerk as performed by the claimant, on a sustained basis." Id.

20 Although the ALJ was not obligated to make a finding at step five, she concluded after considering
 21 the opinions of Mr. Cummings, that Johnson was able to engage in other work existing in significant
 22 numbers in the national economy. (A.R. 35). Specifically, she found that Johnson could perform duties of
 23 an assembler or inspector, that there were approximately 5,000 assembler jobs and 3,000 inspector jobs in
 24 the regional economy, and approximately 161,000 assembler jobs and 40,000 inspector jobs in the national
 25 economy. Id.

26 In summary, the ALJ concluded that Johnson retained the capacity to perform her past relevant work
 27 as a reservations clerk and alternatively, she retained the capacity for other work that exists in significant
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1 numbers in the regional and national economies. She therefore found that Johnson was not disabled as
2 defined by the Act at any time through March 31, 2004, the date last insured. Id.

3 **B. The Parties' Positions**

4 **1. Plaintiff's Motion for Reversal**

5 Plaintiff's Motion for Reversal argues that the ALJ did not fairly evaluate the evidence in this case
6 and only selectively cited those portions of the record that supported denial of Johnson's disability claim.
7 Johnson claims that the opinions of her treating doctors were overlooked or discredited by the ALJ because
8 she did not find objective clinical evidence supporting their opinions and findings. Johnson also argues the
9 ALJ impermissively rejected Johnson's testimony concerning her activities of daily living, and did not cite
10 where in the record Johnson's testimony was inconsistent with complaints of disabling symptoms and
11 limitations. Johnson contends that the ALJ characterized her treatment regimen as conservative despite the
12 fact that Johnson has had several major surgeries. Johnson also points out that the ALJ did not give
13 adequate consideration to the disabling side affects of medications Johnson was taking, and improperly
14 rejected the statement of her mother because she was not a doctor, and was her mother. Johnson asserts that
15 the ALJ misapprehended the nature of her impairments, and that the ALJ's summary of the medical records
16 was "terse, incomplete and not entirely accurate."

17 Johnson contends that the hearing testimony of Dr. Victor Schorn supports a finding of disability
18 because he cited repeated episodes of decompensation when Johnson attempted to return to work, and
19 opined that even if Johnson was able to obtain a position, he doubted that she would be able to fulfill the
20 requirements of an 8-hour day or 40-hour work week. Johnson also argues that the hypothetical questions
21 posed to Mr. Cummings, the vocational expert who testified at the hearing, were inaccurate because the first
22 assumed Johnson retained the capacity to do sedentary work with an additional mild problem in
23 concentrating, and the second assumed the ability to perform sedentary physical work involving simple
24 repetitive tasks with no exposure to the public or co-workers. Based on these inaccurate hypotheticals, Mr.
25 Cummings testified an individual with these limitations would be able to return to work as a reservations
26 clerk.

27 Johnson argues that the Commissioner's decision must be reversed because the ALJ did not consider
28 records of Johnson's treatment prior to January 30, 2002, or only considered them in less than two sentences.

1 Johnson also asserts that the ALJ did not consider Johnson's limitations and restrictions as required by
2 Social Security Ruling 96-8p. Specifically, Johnson claims that although the ALJ acknowledged she
3 suffered from severe impairments, she erred as a matter of law in making the severity determination at step
4 two of the sequential analysis because she did not appropriately evaluate how Johnson's non-exertional
5 impairments affected her functioning. The ALJ did not make a threshold finding concerning whether
6 Johnson suffers from a medically determinable impairment which reasonably could be expected to produce
7 her subjective complaints of pain, headaches and numbness. Because the record was replete with references
8 to these subjective symptoms the ALJ should have, but did not address them. Johnson claims that her
9 complaints of chronic pain are compatible with Social Security Regulation 99-2p, which addresses proof
10 of chronic fatigue syndrome, migraine, somatoform, and like disorders which cannot be established through
11 laboratory or imaging tests. She also relies on Social Security Ruling 96-8p, which requires an adjudicator
12 to explain how any major inconsistencies or ambiguities in the evidence in the case were considered and
13 resolved. In this case, the ALJ did not consider or address Dr. Roth's opinion that Johnson was disabled.

14 Johnson also argues that the ALJ improperly rejected Johnson's testimony concerning pain from
15 migraine headaches and other chronic conditions because of an asserted absence of objective evidence.
16 Johnson claims that her chronic pain syndrome is analogous to other impairments not easily quantified such
17 as Complex Regional Pain Syndrome which is discussed in Social Security Ruling 03-02p. Johnson points
18 out that this regulation provides that chronic pain syndrome cannot be rejected merely because a claimant's
19 complaints are out of proportion to the clinical and laboratory findings, but this is precisely what the ALJ
20 did in evaluating Johnson's pain complaints.

21 Johnson contends the ALJ did not consider all of her impairments together and assess their
22 cumulative affect on her ability to work as required by Social Security Ruling 96-8p. Specifically, she
23 argues that the ALJ did not take into account her significant non-exertional impairments and their
24 cumulative affect on her ability to work. She also contends that the reasons given by the ALJ for
25 discrediting her subjective symptoms did not meet the clear and convincing standard required in the Ninth
26 Circuit. She cites Social Security Ruling 96-7p and Ninth Circuit cases to support her arguments that the
27 ALJ may not discredit a claimant's testimony solely on a perceived lack of objective findings.

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1 She also contends that Mr. Cummings' vocational expert testimony is not supported by substantial
2 evidence because the ALJ posed incomplete hypotheticals. As such, Mr. Cummings' opinions have no
3 evidentiary value. She asserts the ALJ failed to accord proper weight to her treating physicians' medical
4 opinions and made an unsupported finding in the record that no treating or examining physician had opined
5 that Johnson was totally and permanently disabled from all work. Finally, Johnson argues that under
6 established Ninth Circuit precedent, when an ALJ fails to provide adequate reasons for rejecting the opinions
7 of a treating or examining physician, the Court must accept those opinions as a matter of law. Similarly, the
8 Ninth Circuit has held that if an ALJ's reasons for rejecting a claimant's testimony are not supported by clear
9 and convincing evidence, the claimant's testimony must be taken as true. Because there is no suggestion
10 in the record that Johnson is malingering, the reasons given for rejecting her testimony were not clear and
11 convincing. For all of these reasons Johnson asks that the Court remand this case under sentence four of
12 42 U.S.C. 405(g) with instructions to award benefits.

13 **2. Defendant's Motion to Voluntary [sic] Remand.**

14 The Defendant did not oppose Plaintiff's Motion for Reversal or comply with the Court's Scheduling
15 Order (#17). Rather, the Defendant filed a two-page Motion indicating the Commissioner has agreed to a
16 voluntary remand of this case pursuant to sentence four of 42 U.S.C. § 405(g) for further administrative
17 proceedings. The Commissioner suggests the ALJ should be directed to "update the evidentiary record" and
18 offer Plaintiff an opportunity for a new hearing. Specifically, the Commissioner states he will instruct the
19 ALJ to evaluate Plaintiff's diagnosed migraines, chronic pain syndrome, somatoform disorder and
20 myofascial pain syndrome, and determine whether these impairments are severe and what limitations, if any,
21 are caused by these impairments. Additionally, if a sentence four remand is granted, the ALJ will be
22 instructed to address and consider the opinion of Victor Schorn, M.D., that Plaintiff could not work full time
23 and the opinion of David Roth, M.D., that Plaintiff was disabled by chronic pain and was permanently and
24 totally disabled.

25 **3. Plaintiff's Reply to Defendant's Motion for Remand.**

26 Plaintiff filed a Reply arguing the agency's proposal violates the Social Security Act by requesting
27 voluntary remand after the commissioner filed an Answer. Additionally, the Defendant ignores controlling
28 Ninth Circuit authority that if an ALJ improperly rejects testimony and other medical evidence, the

1 testimony and evidence is taken as true as a matter of law. Thus, the Court should exercise its discretion
2 to reverse the ALJ's decision and order payment of disability benefits without remanding this case for a
3 rehearing.

4 **4. Defendant's Reply to Plaintiff's Response (#27).**

5 Defendant filed a Reply which argued that its request for remand for further administrative
6 proceedings is authorized by the Social Security Act, notwithstanding that the Motion was filed after the
7 Defendant's Answer. Defendant also disputes that its Motion for Voluntary Remand is inconsistent with
8 the Court's Scheduling Order. Defendant contends that reversal with full payment of benefits is not
9 appropriate in this case because further administrative proceedings are required for proper resolution of the
10 factual issues. Specifically, the Defendant argues the administrative law judge did not evaluate whether
11 Johnson's migraines, chronic pain syndrome, somatoform disorder, and myofascial pain syndrome were
12 severe at step two of the sequential evaluation procedure. Defendant also asks that the Court remand this
13 case for the ALJ to consider the opinions of Dr. Schorn, an independent medical expert called by the ALJ,
14 and Dr. David Roth, one of Plaintiff's treating physicians. Defendant argues that the "crediting as true"
15 doctrine is not mandatory in the Ninth Circuit, and that payment of benefits should be awarded only in the
16 most unusual case where it is clear from the record that a claimant cannot work.

17 Defendant acknowledges that Dr. Schorn testified that Plaintiff's mental limitations would prevent
18 her from working full time. However, Defendant claims that this opinion was contradicted by the opinion
19 of Miles S. Morgan, who examined the Plaintiff earlier. Thus, the case should be remanded to allow the ALJ
20 to resolve the inconsistencies between the opinions of Dr. Morgan and Dr. Schorn. Remand is also
21 appropriate to address the opinions of Dr. Roth, one of Plaintiff's treating physicians in Massachusetts, who
22 opined Plaintiff was disabled and recommended that she move to the southwest where a warmer, dryer
23 climate would alleviate her pain. After Plaintiff moved, Dr. Roth no longer treated her. Plaintiff was treated
24 by Las Vegas Physician, Michael McKenna. Defendant concedes that the ALJ's analysis of the medical
25 opinion evidence was inadequate but argues the inadequacy of her analysis does not support a payment of
26 benefits.

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1 **5. Plaintiff's Motion to Strike.**

2 Plaintiff filed a Motion to Strike Defendant's Reply to Plaintiff's Response pursuant to Federal Rule
3 of Civil Procedure 12(f) characterizing it as a "reply to a reply" which is not authorized by the Social
4 Security Act, the Rules of Civil Procedure or the Court's Scheduling Order. The Motion to Strike also
5 contends that the ALJ's decision must stand or fall on its own merit and appellate counsel is not entitled to
6 "post hoc rationalization for the agency's action". Finally, Plaintiff contends that adopting the agency's
7 position would render this Court's Scheduling Order meaningless and that the Defendant is improperly
8 attempting to get in the last word when the right to open and close argument belongs to the party who has
9 the burden of proof or affirmative duty to establish a fact or proposition.

10 **6. Defendant's Response to Plaintiff's Motion to Strike.**

11 Not to be outdone, Defendant filed a Response to Plaintiff's Motion to Strike arguing that Motions
12 to Strike are disfavored and should not be granted unless it is clear that the matter to be stricken could have
13 no possible bearing on the subject matter of the litigation.

14 **III. Analysis and Findings**

15 Reviewing the record as a whole, weighing both the evidence that supports and the evidence that
16 detracts from the ALJ's conclusion, the court finds the ALJ's decision is not supported by substantial
17 evidence and that the ALJ committed legal error. The court finds that the ALJ cited selective portions of
18 the medical record supporting denial of disability benefits and completely ignored whole categories of
19 records and opinions of Plaintiff's treating physicians. The Defendant concedes, and the court finds, that
20 the ALJ did not adequately analyze the medical evidence in the record and did not evaluate Johnson's
21 diagnosed migraines, chronic pain syndrome, somatoform disorder and myofascial pain syndrome, or
22 determine whether these impairments are severe and what limitations are caused by these impairments or
23 combination of impairments. The Defendant also concedes, and the court finds, that the ALJ failed to
24 consider the opinions of Dr. Schorn, the independent medical expert the ALJ herself called, and Dr. David
25 Roth, one of Plaintiff's treating physicians who has opined Plaintiff has been permanently and totally
26 disabled since October 27, 1997. The court also finds the ALJ improperly rejected Plaintiff's subjective
27 disabling pain complaints, and committed a number of other legal errors. The following is an illustrative,
28 but by no means exhaustive list of those errors.

1 First, as the Defendant concedes, the ALJ failed to consider or evaluate large portions of the medical
2 evidence in the record indicating Plaintiff has been diagnosed with migraines, chronic pain syndrome,
3 somatoform disorder and myofascial pain syndrome. Again, as the Defendant concedes, the ALJ failed to
4 determine whether these impairments, in combination with the severe impairments the ALJ had already
5 found, significantly limited Johnson from performing basic work activities.

6 Second, the ALJ made a finding at Step Three of the sequential evaluation process that Johnson's
7 impairments did not meet or equal any of the impairments of the Listings. In making this finding she both
8 relied upon and disregarded the opinions of Dr. Schorn, an independent medical examiner she called to
9 provide medical opinion testimony based on his review of the Plaintiff's medical history. On page two of
10 her opinion she states that Dr. Schorn "testified at the hearing that the claimant's impairment is not of a
11 severity to meet or equal any listed impairment." (A.R. 30). However, on page four of her decision, she
12 states:

13 Dr. Schorn testified that there is little objective evidence to support any of the claimant's
14 disabling conditions. Dr. Schorn further testified that if you believe all of her pain and
15 suffering really exists, then a somatoform listing would be met. However, Dr. Schorn's
16 function at the hearing was to opine on the medical evidence of record, which he did, not
17 evaluate the claimants demeanor. For this reason, I accept only his testimony with respect
18 to the contents of the medical evidence.

19 (A.R. 32)(emphasis in original).

20 The court has carefully reviewed Dr. Schorn's testimony. Dr. Schorn summarized his review of the
21 Plaintiff's medical history, complaints, treatment and surgery. He testified that from his review of the
22 medical records he understood the Plaintiff had been involved in at least four automobile accidents
23 beginning in 1994. Work up revealed that she had a C6 nerve root lesion on the right side and that her
24 symptoms fit this diagnosis. She also had an anterior cervical disectomy and fusion at C5-6 on May 4,
25 1995, continued to be symptomatic and was treated symptomatically.

26 He testified that in August 1998, Johnson was involved in another automobile accident which
27 aggravated her neck and gave her additional problems in her low back and left leg. During this time she was
28 also found to have a liver lesion which was asymptomatic. Lymphedema was diagnosed which created
further problems with both of her lower extremities and her feet and she was diagnosed with problems in
her right shoulder. An MRI scan of the right shoulder revealed a fracture with an avulsion of the glenoid

1 tuberocity and a significant tear of her rotator cuff on the right side. This resulted in surgery and repair and
 2 apparently continued to cause her pain. Dr. Schorn's review of the record revealed that "she has actually
 3 generalized pain that seems to involve almost every part of her body." Dr. Schorn did testify, as the ALJ
 4 stated, that Johnson did not have much in the way of objective findings. However, Dr. Schorn pointed out
 5 that Johnson was recently seen by a neurosurgeon "showing some positive findings, primarily a positive
 6 straight-leg raising test on the left side."

7 Although acknowledging there was not much in the way of objective findings, Dr. Schorn plainly
 8 testified, "I think what she has is a chronic pain syndrome." He opined that there were certainly objective
 9 findings in Johnson's past indicating that she had organic injuries. He reiterated that she had four
 10 automobile accidents--in 1994, 1998, 2003 and 2005. He also testified that based on his own evaluation,
 11 Johnson's symptoms were real. He testified:

12 I feel that her symptoms are real; . . . I feel that **she has a chronic pain syndrome which I**
 13 **think would equal the somatoform disorder.** And when I say somatoform, I don't think
 14 the symptoms are somatoform, but I think the syndrome equals a somatoform disorder where
 15 she has significant pain but—that has caused her to see a physician frequently. It has certainly
 16 altered her life patterns, and it has significantly interfered with her movement and ability to
 17 function. And I think that it has resulted in at least marked . . . or moderate restrictions of
 18 her activities of daily living . . . moderate to marked difficulties in social functioning. . . .
 19 more difficulties in maintaining concentration, persistence, and pace, **and she has had**
 20 **repeated episodes of decompensation when she attempted to return to work.** It's my
 21 opinion also that **even if she were able to obtain a position, I doubt that if she could**
 22 **fulfill the required eight-hour day or forty-hour work week.**

23 (A.R. 625-626)(emphasis supplied).

24 The ALJ questioned Dr. Schorn about these findings and asked what limb he was referring to under
 25 Listing "(a)(2)(d)". Dr. Schorn responded that he was referring primarily to Johnson's right arm and her left
 26 leg, and that Johnson also had problems with sensory loss. The ALJ specifically asked Dr. Schorn whether
 27 he was basing these opinions on information preceding the date last insured, or whether he was "considering
 28 her testimony about how she is now and the more recent medical records?" (A.R. 627). Dr. Schorn
 29 responded "no, I am not. Primarily based on the record that I have, Your Honor, that precedes the
 30 expiration of date of 2004 (sic)." Id.

31 As indicated, the ALJ's decision rejected Dr. Schorn's testimony that Johnson suffered from a
 32 somatoform disorder because his "function at the hearing was to opine on the medical evidence of record,
 33 which he did, not evaluate the claimant's demeanor." (A.R. 32). However, it is clear from Dr. Schorn's
 34

1 testimony that he based his opinion on his medical review of the record as a whole preceding Johnson's date
2 last insured—March 31, 2004. He specifically and unequivocally testified that he did not base these opinions
3 on her testimony at the hearing and the more recent medical records. Dr. Schorn reiterated his testimony
4 that the Plaintiff suffered from a chronic-type of pain syndrome that equals a somatoform disorder. He
5 concluded:

6 It really boils down to whether I believe whether she's having symptoms or not. I tend to
7 believe that these are real to her, and have caused significant limitation in her lifestyle and
her ability to function as she would like.

8 Id.

9 The court finds the ALJ erred in rejecting Dr. Schorn's testimony that the Plaintiff suffers from a
10 somatoform disorder, which equals an impairment in the Listing. She rejected his opinion because his
11 function was to opine on the medical evidence of record, not evaluate the claimant's demeanor. However,
12 his testimony is clear that he based his opinions on the medical record and was **not** basing his opinions on
13 Johnson's hearing testimony. Nothing in the record supports even a suggestion that he was basing his
14 opinions on Johnson's demeanor during the hearing. Dr. Schorn's uncontradicted finding that Johnson
15 suffers a medical impairment that equals a Listing conclusively establishes disability. The ALJ committed
16 clear error in concluding in one portion of her opinion that Dr. Schorn opined Johnson's impairment is not
17 of a severity to meet or equal any listed impairment. Nothing in the record supports this finding. She also
18 erred in rejecting his testimony that Johnson suffers from a somatoform disorder which equals an
19 impairment in the Listing.

20 Third, the ALJ committed legal error in finding that the administrative record did not support a
21 finding of episodes of decompensation. Dr. Schorn testified that Johnson has had repeated episodes of
22 decompensation when she attempted to return to work. The administrative record supports the opposite
23 finding. Johnson experienced repeated episodes of decompensation when she attempted to return to work.

24 Fourth, the ALJ committed legal error in finding that no treating or examining physician has opined
25 that Johnson is totally and permanently disabled from all work. The ALJ made a passing reference to Dr.
26 Roth's April 14, 2003 report indicating that he had been treating the claimant since 1995 for a herniated disc
27 for which she underwent surgery and chronic degenerative lumbar disease. However, inexplicably she
28 completely ignored Dr. Roth's July 21, 2004, May 10, 2006 and September 5, 2006 written opinions that

1 Johnson became totally and permanently disabled beginning on October 27, 1997. (A.R. 202, 540). Dr.
 2 Roth diagnosed Plaintiff with “(a) herniated cervical disc followed by cervical fusion and residual permanent
 3 nerve damage; (b) fibromyalgia; (c) myofascial pain syndrome; (d) lumbar discogenic degenerative disease
 4 with pain; (e) L5-S1 disc herniation; (f) osteoporosis in the hips, spine, and forearm.”
 5 (A.R. 541). As a result of these diagnoses, Dr. Roth concluded Johnson was totally and permanently
 6 disabled for any kind of employment. (A.R. 541).

7 The implementing regulations for Title II of the Social Security Act distinguish among the opinions
 8 of three types of physicians: first, treating physicians; second, examining physicians (*i.e.* physicians who
 9 examine but do not treat a claimant); and third, non-examining or reviewing physicians (*i.e.* physicians who
 10 neither examine nor treat the claimant, but review the claimant’s file). Lester v. Chater, 81 F.3d, 821, 830
 11 (9th Circuit 1995); 20 C.F.R. § 404.1527(d). Generally, a treating physician’s opinion is entitled to more
 12 weight than an examining physician’s, and an examining physician’s opinion is entitled to more weight than
 13 a reviewing physician’s. Lester, 81 F.3d at 830; 20 C.F.R. § 404.1527(d). The social security regulations
 14 give more weight to opinions that are explained than those that are not. 20 C.F.R. § 404.1527(d)(3). The
 15 social security regulations also give more weight to opinions of specialists concerning matters relating to
 16 their specialty over that of non-specialists. 20 C.F.R. § 404.1527(d)(5).

17 In disability benefits cases, physicians typically provide medical opinions that address the nature and
 18 extent of the claimant’s limitations, and opinions concerning “the ultimate issue of disability”, *i.e.* opinions
 19 about whether a patient is capable of any work given her limitations. Holohan v. Massanari, 246 F.3d 1195,
 20 1202 (9th Cir. 2001). “Under the regulations, if a treating physician’s medical opinion is supported by
 21 medically accepted diagnostic techniques that is not inconsistent with other substantial evidence in the
 22 record, the treating physician’s opinion is given controlling weight.” Id, (citing 20 C.F.R. § 404.1527(d)(2)
 23 and Social Security Ruling 96-2p). To reject the uncontradicted medical opinion of a treating physician, an
 24 ALJ must provide “clear and convincing” reasons supported by substantial evidence in the record. Id, (citing
 25 Reddick v. Chater, 157 F.3d, 715, 725 (9th Cir. 1998)). Treating source medical opinions are entitled to
 26 deference even if inconsistent with the substantial evidence in the record and treating physician’s medical
 27 opinions must be weighted using all of the factors provided in 20 C.F.R. § 404.1527. Id, (citing SSR 96-2p).
 28 “An ALJ may rely on the medical opinion of a non-treating doctor instead of the contrary opinion of the

1 treating doctor only if she or he provide ‘specific and legitimate’ reasons supported by substantial evidence
 2 in the record.” *Id.* (citing Lester, 81 F.3d at 830). Similarly, an ALJ may not reject a treating physician’s
 3 uncontradicted opinion on the ultimate issue of disability unless there are “clear and convincing” reasons
 4 supported by substantial evidence in the record. *Id.* Even if the treating physician’s opinion on the issue
 5 of disability is controverted, the ALJ must provide “specific and legitimate” reasons to reject a treating
 6 physician’s opinion. *Id.*

7 In this case, the ALJ did not even discuss the opinion of Plaintiff’s treating physician, Dr. Roth, that
 8 Johnson became totally and permanently disabled beginning October 27, 1997 for reasons he detailed in his
 9 reports dated July 21, 2004, May 10, 2006, and September 5, 2006. Each of these reports were in the
 10 Administrative Record, but completely ignored by the ALJ. The ALJ did not provide any reasons, let alone
 11 clear and convincing reasons for rejecting Dr. Roth’s conclusion that Johnson has been totally and
 12 permanently disabled for any kind of employment since October 27, 1997.

13 Fifth, the court finds the ALJ improperly rejected Johnson’s subjective complaints of incapacitating
 14 fatigue and pain. The ALJ found that Johnson retained the residual functional capacity to perform her past
 15 relevant work as a reservation clerk and was therefore not disabled. In assessing Johnson’s residual
 16 functional capacity, the ALJ considered Johnson’s claims of disabling pain and functional limitations and
 17 found by clear and convincing evidence that Johnson’s subjective allegations were not fully credible. The
 18 court finds the ALJ erred and that her findings were not supported by clear and convincing evidence.

19 In the Ninth Circuit, once a claimant produces objective medical evidence establishing an impairment
 20 that could reasonably be expected to cause **some** pain, an ALJ may not discredit the claimant’s allegations
 21 of the severity of the pain solely on the ground that the allegations are unsupported by objective medical
 22 evidence. *Cotton v. Bowen*, 799 F.2d 1403, 1407 (9th Cir. 1986)(per curiam). The Ninth Circuit recognizes
 23 that “unlike most medical conditions capable of supporting a finding of disability, pain cannot be objectively
 24 verified or measured.” *Fair v. Bowen*, 885 F.2d 597, 601 (9th Cir. 1989). The existence and degree of pain
 25 “is a completely subjective phenomenon.” *Id.* Because of this, “it is possible to suffer disabling pain even
 26 where the *degree* of pain as opposed to the mere *existence* of pain, is unsupported by objective medical
 27 findings.” *Id.* (emphasis in original). This type of pain is typically referred to in the cases as “excess pain”.
 28 *Id.* Definitionally, excess pain is “at a level above that supported by medical findings”. *Id.* It is improper

1 as a matter of law for an ALJ to discredit excess pain testimony solely on the ground that it is not fully
 2 corroborated by objective medical findings because permitting an ALJ to disbelieve pain testimony solely
 3 on this ground would permit denial of benefits to claimants whose pain, in fact, prevents them from working.
 4 *Id* at 601-602.

5 In this case, it is undisputed that Johnson has a variety of medical impairments that can be expected
 6 to cause pain. Thus, the ALJ could not simply reject Johnson's subjective complaints based solely on a lack
 7 of objective medical evidence to fully corroborate the alleged severity of her pain. "In order to disbelieve
 8 a claim of excess pain, an ALJ must make specific findings justifying that decision." Fair v. Bowen, 885
 9 at 602. Such findings discrediting a claim of excess pain "must be sufficiently specific to allow a reviewing
 10 court to conclude the adjudicator rejected the claimant's testimony on permissible grounds and did not
 11 'arbitrarily discredit a claimant's testimony regarding pain.'" Bunnell v. Sullivan, 947 F.3d 341, 345-345
 12 (9th Cir, 1991).

13 Social Security Ruling 88-13 was implemented to assist ALJs in making the required findings. *Id*
 14 at 346. Once a claimant establishes a medical impairment reasonably likely to cause pain, SSR 88-13
 15 requires the ALJ to consider "all of the available evidence" because "pain is subjective and not susceptible
 16 to measurement by reliable techniques." *Id*, (citing SSR 88-13). A number of the reasons given by the ALJ
 17 for finding Johnson's subjective allegations not fully credible are plainly wrong. For example, she found
 18 Dr. Schorn testified there is little objective evidence to support any of the claimant's disabling conditions.
 19 Dr. Schorn in fact testified that Johnson suffered from a number of disabling conditions, that her
 20 combination of impairments equaled the somatoform disorder and that he believed Johnson was incapable
 21 of working.

22 The ALJ also found that Johnson's treatment "has been relatively conservative." However, Johnson
 23 has undergone multiple surgical procedures over the years. She was involved in her first automobile
 24 accident May 5, 1994. After a year of physical therapy, pain medication and multiple visits to multiple
 25 specialists for treatments, she underwent a cervical analgesic diskography on March 15, 1995 and an anterior
 26 cervical micro discectomy at C5-6 on May 4, 1995. Before undergoing the discectomy and fusion, she saw
 27 multiple physicians. In an office visit with Dr. Jules Nazarro on October 20, 1994, Johnson told Dr. Nazarro
 28 she felt she had exhausted conservative measures to treat her and asked to be evaluated by an outside

1 neurosurgeon. She was. However, Dr. Nazarro recommended against surgical intervention. Dr. Fullerton
 2 and Johnson's physical therapist thought she should be considered for surgery in September 1994, and
 3 Johnson was referred to a microsurgeon, Dr. McCann, on October 12, 1994. Dr. Roth ultimately performed
 4 the surgery May 4, 1995 after analgesic injections proved ineffective in eliminating her pain.

5 Johnson's medical records are replete with references to diagnosis and treatment for chronic pain.
 6 She has been diagnosed with chronic pain by multiple treating physicians, and treated by three chronic pain
 7 specialists. She treated with Dr. Popovich, a pain manage specialist beginning in November 1995 through
 8 June 11, 1997. Dr. Popovich diagnosed Johnson with status post surgical decompression of C6 nerve root
 9 and myofascial pain syndrome with trigger points. Dr. Popovich administered lidocaine injections,
 10 prescribed additional physical therapy treatment, and prescribed a variety of medications to treat Johnson's
 11 pain. In the spring of 1996, Johnson was diagnosed by Dr. Tad S. Davis with major depressive disorder and
 12 chronic pain syndrome resulting from her inability to control and manage the pain in her back. Dr. Davis
 13 recommended that Johnson participate in an intensive chronic pain management program. However,
 14 Johnson had exhausted her rehabilitation benefits and could not afford the recommended treatment.

15 The ALJ also discredited Johnson's claim of disabling pain on the grounds "no treating or examining
 16 physician had opined that the claimant is totally and permanently disabled from all work." For the reasons
 17 discussed in detail, *infra*, this finding is clearly erroneous.

18 The ALJ also found, that the claimant was able to participate in the administrative hearing and
 19 respond to questioning without any apparent difficulties in support of her finding, Johnson was not credible.
 20 However, in the Ninth Circuit the fact that a claimant does not exhibit manifestations of pain at the hearing
 21 before the ALJ is, of itself, insufficient to rebut a claim of pain. Fair v. Bowen, 885 F.2d at 602.

22 The ALJ found Johnson lacked credibility because her statement contradicted her testimony that "she
 23 does not drive but yet drives the kids". Her testimony at the hearing was that she drives two or three times
 24 a week to take her son to school or run to the drugstore at the end of the street or to the grocery store. (A.R.,
 25 605). She testified that she only drives occasionally because the medication she takes makes it unsafe for
 26 her to drive a car and she has numbness and pain in her lower back and onto her legs. Id.

27 The ALJ also discredited her testimony concerning disabling pain and functional limitations because
 28 Johnson's activities of daily living "are not limited to the extent one would expect" and because she "is

1 apparently able to care for young children at home . . . with only some assistance." It is unclear, because
2 there are no findings, what activities of daily living the ALJ found were inconsistent with her complaints
3 of disabling symptoms and limitations. Johnson testified that a girlfriend and her husband do most of the
4 grocery shopping. Id at 617. Johnson has a housekeeper who does all of the household chores including
5 the dishes. Johnson's husband does the cooking, although Johnson uses the microwave. Id. Johnson
6 usually gets out of bed at 6:30 a.m. or 7:00 a.m. and goes to bed between 9:00 p.m. and 9:30 p.m. Id at 616.
7 She estimated that she sleeps approximately three hours a night and gets up throughout the night. Id. She
8 takes pain medication before she goes to bed and additional pain medication in the middle of the night. Id.
9 She naps three to four times throughout the day between forty-five minutes and two hours at a time. Id at
10 616-617. She tries to swim in the pool and do exercises. Id at 618. She sits and interacts with her children
11 and watches them play and "that's pretty much it." She occasionally accompanies her husband and children
12 to watch her children bowl. Id. However, while the children bowl a couple of games, she has to get up and
13 move and go and sit in different spots. Id. She is unable to bathe and, therefore, takes showers. Id. It is
14 difficult for her to wash her hair. Id at 619. It is difficult for her to wash her legs and she does not shower
15 everyday. Id. She has difficulty putting on bras and sports bras and slips her shoes on without tying them.
16 Id at 619.

17 Her children were eight and four at the time of the hearing. Id at 621. When asked who takes care
18 of her children, Johnson responded that her husband is home a lot and that a friend down the street helps her.
19 Id. Her husband works evenings and midnight shifts. She car pools with a neighbor and another group and
20 sometimes drives her children to school. Id. Aside from watching the family bowling, Johnson's other
21 activities consist of watching her kids play on their bikes or play baseball or football. Id. The family
22 occasionally goes out to dinner or her husband will bring food home.

23 Limitations of time, space and resources prevent the court from detailing all of the ALJ's findings
24 that are not supported by substantial evidence in the record. Suffice it to say, the ALJ's findings that
25 Johnson's activities of daily living and apparent ability to take care of her small children indicate she is not
26 disabled by pain are not supported by substantial evidence in the record. There is ample subjective and
27 supporting objective clinical evidence of Johnson's disabling pain in the record which the ALJ ignored
28 entirely or rejected. Viewing the record as a whole, it is clear that multiple treating physicians who have

1 examined and treated Johnson over the years have concluded that Johnson suffers from a variety of
 2 conditions that cause her constant pain.

3 Sixth, the testimony of Mr. Cummings, the vocational expert called by the ALJ, also does not
 4 constitute substantial evidence to support the ALJ's findings. The ALJ asked two hypothetical questions
 5 which were not supported by the medical evidence in the record. First, Mr. Cummings was asked to assume
 6 that Johnson suffered from a mild limitation in sustaining attention toward the end of the day and was
 7 capable of sedentary work. Based on the this hypothetical, Mr. Cummings testified she would be capable
 8 of performing her past work as a reservation agent. The second hypothetical posed was to assume Johnson
 9 was capable of sedentary, simple, repetitive tasks with little contact with the public or co-workers.
 10 Cummings opined that Johnson could work as an inspector or assembler. (A.R. 632-633). However,
 11 Johnson's attorney asked Mr. Cummings if a person who couldn't work eight hours a day, five days a week
 12 without frequent breaks for rest, taking pain medication, and needing naps, could do these jobs. Mr.
 13 Cummings responded, "Yes, it would suggest to me that the person would not have the capacity to perform
 14 full-time work." Id at 333. Here the ALJ did not ask the vocational expert hypotheticals which set forth all
 15 of Johnson's impairments. Additionally, when cross-examined by Johnson's attorney, Mr. Cummings
 16 testified that a person who could not work eight hours a day, five days a week, and who needed to take
 17 frequent breaks for rest, pain medication, and who needed to nap would not have the capacity to perform
 18 full-time work.

19 "If a vocational expert's hypothetical does not reflect all the claimant's limitations, then the 'expert's
 20 testimony has no evidentiary value to support a finding that the claimant can perform jobs in the national
 21 economy.'" Matthews v. Shalala, 10 F.3d 678, 681, (citing DeLorne v. Sullivan, 924 F.2d 841, 850 (9th Cir.
 22 1991)). The vocational expert's testimony in this case did not reflect the evidence of Johnson's medical and
 23 functional impairments. In fact, the vocational expert's testimony taken as a whole strengthens Johnson's
 24 disability claim. Accordingly, the ALJ's conclusion that Johnson could engage in substantial gainful activity
 25 is not supported by substantial evidence.

26 As indicated, these are merely six examples of the errors made by the ALJ in this case. As the ALJ's
 27 decision is not supported by substantial evidence and contains reversible error, remand is required.

28 ///

1 **IV. Remand**

2 After finding that the ALJ erred, this court has discretion to remand for further proceedings and
 3 additional evidence or for an award of benefits. Harmon v. Apfel, 211 F.3d 1172, 1178 (9th Cir. 2000). The
 4 decision whether to remand for further proceedings or for an award of benefits is within the court's
 5 discretion. Reddick v. Chater, 157 F.3d 715, 728 (9th Cir. 1998).

6 Sentence four and sentence six of 42 U.S.C. § 405(g) set forth the exclusive methods by which
 7 district courts may remand to the Commissioner of the SSA. Shalala v. Schaefer, 509 U.S. 292, 296 (1993);
 8 Melkonyan v. Sullivan, 501 U.S. 89, 99-100 (1991).

9 Sentence four provides that “[t]he [district] court shall have power to enter, upon the pleadings and
 10 transcript of the record, a judgment affirming, modifying, or reversing the decision of the Commissioner of
 11 Social Security, with or without remanding the cause for a rehearing.” 42 U.S.C. § 405(g). The fourth
 12 sentence directs the entry of a final, appealable judgment and provides that a district court may enter
 13 judgment with or without remanding the case for a rehearing. Sullivan v. Finkelstein, 496 U.S. 617, 629
 14 (1990). In a sentence four remand, the court determines whether the ALJ properly considered the claimant's
 15 application for benefits. Melkonyan, 501 U.S. at 100.

16 Under sentence six, by contrast, the court may remand without making a determination concerning
 17 the correctness of the ALJ's decision. Id at 100. Remand under sentence six is “an entirely different kind
 18 of remand. The district court does not affirm, modify, or reverse the Secretary's decision; it does not rule
 19 in any way as to the correctness of the administrative determination.” Id at 98 (quoting Finkelstein, 496 U.S.
 20 at 626). The Supreme Court has held that sentence six remands may be issued only in two situations: “where
 21 the Secretary [Commissioner] requests a remand before answering the Complaint, or where new, material
 22 evidence is adduced that was for good cause, not presented before the agency.” Shalala v. Schaefer, 509
 23 U.S. at 292, 297 n.2 (1993).

24 Under a sentence six remand, the Secretary must return to the district court after remand to file any
 25 additional or modified findings of fact and decision, as well as a transcript of the additional record and
 26 testimony upon which the Commissioner's action in modifying or affirming was based. 42 U.S.C. § 405(g);
 27 Melkonyan, 501 U.S. at 98. The district court, therefore, retains jurisdiction over the matter in a remand
 28 ///

1 under sentence six of 42 U.S.C. § 405(g) and issues a final judgment after the Secretary returns to the court
 2 with his additional or modified findings. Melkonyan, 501 U.S. at 103.

3 The Ninth Circuit has “repeatedly held that a remand for further proceedings is unnecessary if the
 4 record is fully developed and it is clear from the record that the ALJ would be required to award benefits.”
 5 Holohan v. Massanari, 246 F.3d 1195 (9th Cir. 2001)(collecting cases). The Ninth Circuit adopted this rule
 6 because it recognized the importance of expediting disability claims. Id. The Ninth Circuit has also
 7 recognized that where “it is evident from the record that benefits should be awarded, remanding for further
 8 proceedings would needlessly delay effectuating the primary purpose of the Social Security Act, ‘to give
 9 financial assistance to disabled persons because they are without the ability to sustain themselves.’” Id.
 10 (citing Gamble v. Chater, 68 F.3d 319, 322 (9th Cir. 1995)(internal quotation marks and citation omitted)).

11 In Lester v. Chater, the Ninth Circuit held that when an ALJ fails to provide adequate reasons for
 12 rejecting the opinion of a treating or examining physician, the court may credit that opinion as a matter of
 13 law. 81 F.3d 821, 834 (9th Cir. 1995). In Smolen v. Chater, 80 F.3d 1273 (9th Cir. 1996), the Ninth Circuit
 14 expanded the credit as a matter of law rule, and developed a three-part test for determining when evidence
 15 should be credited and an immediate award of benefits directed. Improperly rejected evidence should be
 16 credited as true and an immediate award of benefits directed where “(1) the ALJ has failed to provide legally
 17 sufficient reasons for rejecting such evidence, (2) where there are no outstanding issues that must be resolved
 18 before a determination of disability can be made, and (3) it is clear from the record that the ALJ would be
 19 required to find the claimant disabled or such evidence credited.” Harmon, 211 F.3d at 1178, (citing
 20 Smolen, 80 F.3d at 1292). Where it is not clear the ALJ would be required to award benefits were the
 21 improperly rejected evidence credited, the court has discretion whether to credit the evidence. Connett v.
 22 Barnhart, 340 F.3d 871, 876 (9th Cir. 2003).

23 The court finds this case must clearly be remanded for immediate payment of benefits. Because the
 24 ALJ failed to address, let alone provide adequate reasons for rejecting Dr. Roth’s opinion that Johnson has
 25 been totally and permanently disabled since October 27, 1997, the court credits his opinion as a matter of
 26 law. An examination of the record as a whole reveals ample support for Johnson’s subjective complaints
 27 of disabling pain and functional limitations. The ALJ’s own medical examiner testified that Johnson suffers
 28 from a somatoform disorder which equals a Listing impairment. The ALJ improperly rejected his testimony

1 on grounds not supported in the record. The Commissioner concedes that the ALJ failed to evaluate
2 Johnson's diagnosed migraines, chronic pain syndrome, somatoform disorder and myofascial pain syndrome.
3 The Commissioner concedes the ALJ failed to determine whether these conditions are severe and what
4 limitations they cause. Finally, the Commissioner concedes the ALJ failed to consider the opinions of her
5 own consultant and asks that the court remand under Sentence Four to consider his opinions as well as the
6 opinions of Dr. Roth, Plaintiff's treating physician, that Plaintiff is permanently and totally disabled.
7 Remanding this case for further proceedings would needlessly delay the primary purpose of the Social
8 Security Act, to provide financial assistance to disabled persons because they lack the ability to sustain
9 themselves.

10 For all of the foregoing reasons, **IT IS RECOMMENDED** that:

- 11 1. Johnston's Motion to Remand and Reverse (Dkt. #20) be **GRANTED**, and the ALJ's
12 decision reversed and this case **REMANDED** pursuant to Sentence Four of 42 U.S.C. §
13 405(g) for the calculation and award of benefits, and **JUDGMENT** be entered in Johnson's
14 favor.
- 15 2. The Commissioner's Motion to Remand (Dkt. #25) be **DENIED**.
- 16 3. Johnson's Motion to Strike (Dkt. #28) be **DENIED**.

17 Dated this 28th day of April, 2010.

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20 PEGGY A. SEEN
21 UNITED STATES MAGISTRATE JUDGE
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